Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: South Dakota
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): CHIP and CHIP-NM

SCHIP Program Type:
____Medicaid SCHIP Expansion Only
_____Separate SCHIP Program Only
__X__Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

Contact Person/Title: Damian Prunty, Administrator

Address: 700 Governor's Drive; Pierre, South Dakota 57501-5246

Phone: 605-773-3495 Fax: 605-773-5246

Email: Medicaid@DSS.state.sd.us
Submission Date: December 28, 2001

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility

NC in M-SCHIP.
NC in S-SCHIP.

B. Enrollment process

NC in M-SCHIP.
NC in S-SCHIP.

No change in the actual enrollment process, however, the application form has been revised to make it easier to understand and complete. SCHIP WEB site changes were made to include additional links from and to other medical related sites. See WEB sites: www.state.sd.us/social/medical/chip and www.state.sd.us/social/MedElig/.

Attachment: 301-M

C. Presumptive eligibility

NC in M-SCHIP.
NC in S-SCHIP.

D. Continuous eligibility

NC in M-SCHIP.
NC in S-SCHIP.

E. Outreach/marketing campaigns

The Community Healthcare Association of Sioux Falls, South Dakota was a successful applicant for the South Dakota Covering Kids Initiative through grant funding from the

Robert Wood Johnson foundation for a three-year period of time from July 1, 2000 through June 30, 2003. The South Dakota Covering Kids Initiative has four goals. They are: designing and conducting outreach programs to identify and enroll children in the Medicaid and SCHIP programs; continuing to simplify access to and completion of enrollment information and applications; assisting in coordinating coverage programs for low income, uninsured children; and designing programming specifically targeted to Native Americans and other special populations. The program will feature statewide initiatives to meet these goals and also pilot programs to address specific geographic areas and special populations.

F. Eligibility redetermination process

M-SCHIP and S-SCHIP Review Process:

All possible medical program eligibility is explored before a recipient is closed from medical assistance. Eligibility remains until a determination of ineligibility is made. Once eligible for a medical assistance provision, the child can move from one medical assistance provision to another without another application so long as there is not a break (at least 30 days) in eligibility.

Medical reviews must be completed annually. However, any of the following may be used as review documentation:

- Information already available in the case record (Food Stamp or TANF monthly report form, Transitional Medical Benefit quarterly report form, or information reported and verified by the client verbally, or in writing along with applicable verifications)
- Completion of a 301R Medical Review form
- Completion of a new 301M Medical application form
- Completion of a new 301 (Food Stamp or TANF application)

No signed application or interview is required for a medical review. Caseworkers may complete the review form via a telephone contact to the head of household. Any requested documentation may be submitted via mail or fax. If at the established review time there is sufficient information available to redetermine eligibility, then the medical review is considered complete.

If no existing information is available to complete the review, then at least two client contacts will be made in an attempt to gather needed review information.

Attachment 1: 301-R; 205-M

G. Benefit structure

NC in M-SCHIP.
NC in S-SCHIP.

H. Cost-sharing policies

NC in M-SCHIP.
NC in S-SCHIP.

I. Crowd-out policies

NC in M-SCHIP.
NC in S-SCHIP.

J. Delivery system

NC in M-SCHIP.
NC in S-SCHIP.

K. Coordination with other programs (especially private insurance and Medicaid)

The key programs providing creditable coverage for low-income children in South Dakota are the Medicaid and M-SCHIP programs that are jointly administered with the S-SCHIP program. There is no other State efforts for creditable health coverage programs.

The Indian Health Service (IHS) continues as a provider of creditable coverage to Indian children. The IHS functions as a provider of services and also provides coverage for certain specialty services through their contract health program. Coordination with the SCHIP programs and Medicaid is continuous.

The IHS also plays a very important role in the delivery of outreach services to facilitate the identification and enrollment of children for Medicaid and SCHIP. This role will continue for potentially eligible SCHIP children using the established means to interface with the Department of Social Services medical assistance programs.

There are no other public programs providing creditable coverage to low-income children. Children potentially eligible for other public programs will be referred to those programs for services in addition to those provided by Medicaid, M-SCHIP or S-SCHIP.

Also see section 1.1.E: Outreach/Marketing campaigns.

L. Screen and enroll process

NC in M-SCHIP.
NC in S-SCHIP.

M. Application

Minor revisions were made to the 301-M application to make it more user friendly and easier to understand for a lower level of reading ability.

Attachment 1: 301-M

N. Other

NC in M-SCHIP.
NC in S-SCHIP.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The following table shows the number of uninsured children that have been enrolled in SCHIP at the end of each federal fiscal year of SCHIP operation. It also shows the overall enrollment of uninsured children since the implementation of SCHIP July 1, 1998.

Period	Medicaid Increase (children WITHOUT insurance)	M-SCHIP Increase (Program implemented 07-01-98)	S-SCHIP Increase (Program implemented 07-01-00)	Total
FFY 98 07/01/1998-09-30-1998	1,188	903		2,091
FFY 99 10-01-1998-09-30-1999	2,381	1,585		3,966
FFY 00 10-01-1999-09-30-2000	2,265	1,891	301	4,457
FFY' 01 10-01-2000-09-30-2001	3,959	1,456	1,034	6,449
From SCHIP implementation: 07-01-98-09-30-01	**9,793**	**5,835**	**1,335**	**16,963**

Data is from South Dakota Medicaid and SCHIP programs enrollment data.

In FFY 2001 we have added 6,449 uninsured children to Medicaid, M-SCHIP, and S-SCHIP. The overall growth in all three programs since the implementation of SCHIP totals 16,963 **uninsured** children.

This chart clearly demonstrates substantial progress in providing health insurance coverage to **uninsured** children in South Dakota.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

QUARTER ENROLLMENTS SINCE THE IMPLEMENTATION OF SCHIP 7-1-98 For MEDCAID, M-SCHIP & S-SCHIP

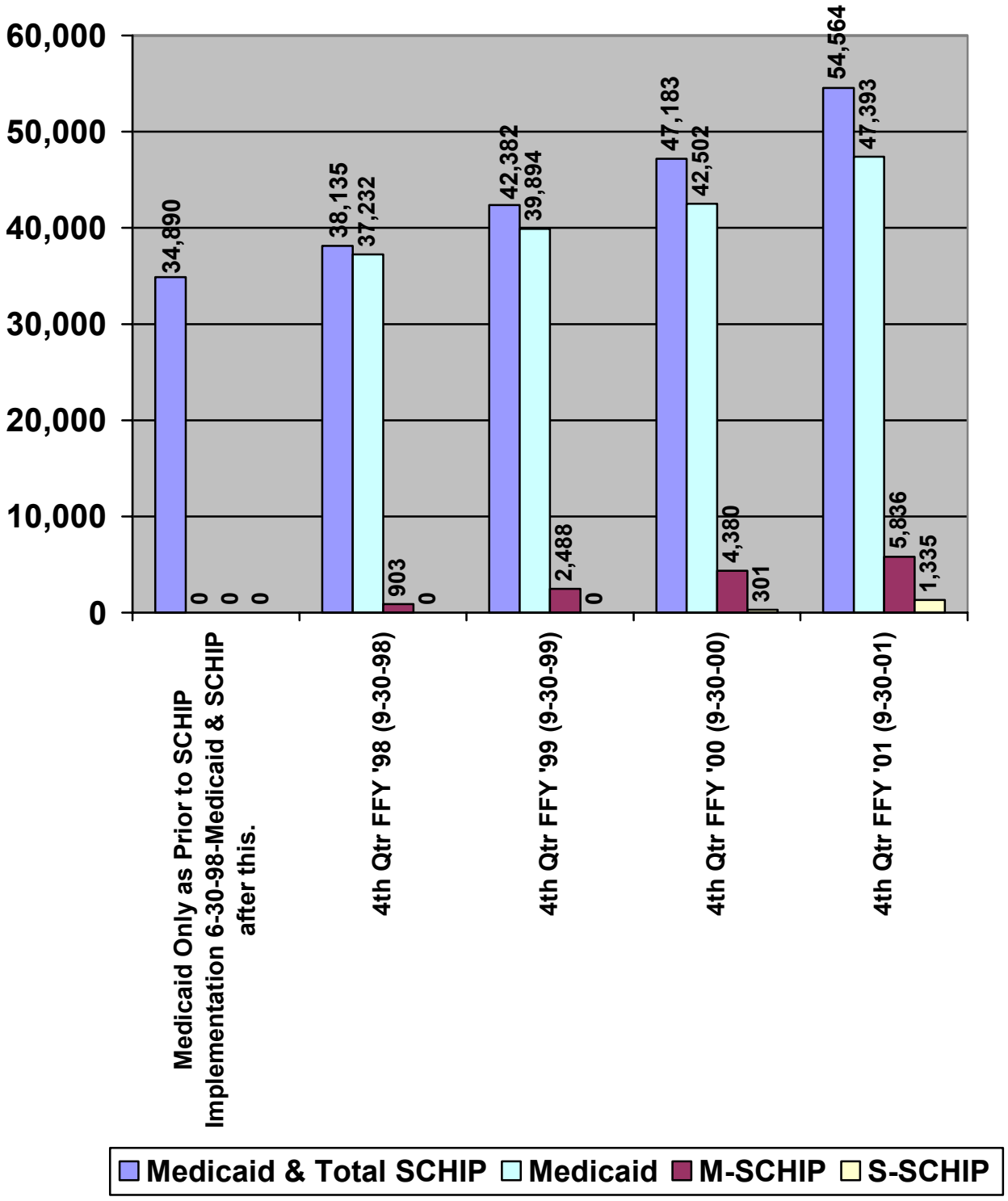
The following table reports the number of enrolled Medicaid, M-SCHIP and S-SCHIP children for the ending date of each quarter from M-SCHIP and S-SCHIP implementation. In this chart when the number of Medicaid eligible children is referred to, it includes all categories of Medicaid eligible children except SSI Medicaid eligible children (1st five columns of numbers are without SSI children figured in; the last column shows TOTAL children on Medicaid & SCHIP including the children on SSI). See the following chart and graph regarding enrollment data.

Quarter Ending	MEDICAID Children (Does not include children on SSI)	M-SCHIP Children (Implemented 07-01-1998)	S-SCHIP Children (Implemented 07-01-2000)	TOTAL SCHIP Children	TOTAL MEDICAID & SCHIP Children (Does not include children on SSI)	TOTAL MEDICAID & SCHIP Children INCLUDING children on SSI (from MMIS
06/30/1998 *	32,859	-0-	-0-	-0-		34,890
09/30/1998 (4th Quarter FFY' 98)	34,290	903	-0-	903	35,193	38,135
12/31/1998	35,320	1,407	-0-	1,407	36,727	39,559
03/31/1999	36,435	1,710	-0-	1,710	38,145	40,970
06/30/1999	36,866	2,039	-0-	2,039	38,905	41,664
09/30/1999 (4th Quarter FFY' 99)	37,158	2,488	-0-	2,488	39,646	42,382
12/31/1999	37,768	2,790	-0-	2,790	40,558	43,225
03/31/2000	39,195	3,179	-0-	3,179	42,374	45,043
06/30/2000	39,538	3,725	-0-	3,725	43,263	45,933
09/30/2000 (4th Quarter FFY' 00)	39,887	4,380	301	4,681	44,568	47,183
12-31-2000	40,841	4,934	621	5,555	46,396	48,965
03-31-2001	42,550	5,331	946	6,277	48,827	51,525
06-30-2001	43,974	5,518	1,211	6,729	50,703	53,261
09-30-2001 (4th Quarter FFY' 01)	44,658	5,836	1,335	7,171	51,829	54,564

- Last Quarter Prior to M-SCHIP and S-SCHIP Implementation.
  Source: South Dakota MMIS 1998, 1999, 2000, 2001

Extracted data from the MMIS over this time period revealed that 83% of the children enrolled in Medicaid were uninsured when considering all types of insurance including full coverage, and limited coverage plans including hospital only, dental and cancer. All M-SCHIP and S-SCHIP children were by definition, uninsured.

Quarter Enrollments Since Implementation of SCHIP
(SCHIP Implemented 07-01-1998 - Quarter Enrollments at end of each FFY)
Data from MMIS and MR63



C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

The enrollment data in the table in 1.2.A shows that there has been an increase in Medicaid of 9,793 children, 5,835 children enrolled in M-SCHIP, and 1,335 children enrolled in S-SCHIP for a total increase of 16,963 children that have insurance coverage since the inception of SCHIP July 1,1998.

See table in 1.2.B.
Attachment 14: County Enrollment Map for September, 2001

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

_____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

The Census Bureau Current Population Survey (CPS), based upon its three year averages for 1997, 1998, and 1999, reported 13,000 uninsured children under 200% of the FPL for South Dakota.

What was the justification for adopting a different methodology?

NC (have not adopted a different methodology).

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The State believes the CPS estimate was the best source of baseline data available for the number of uninsured children when SCHIP was implemented. However, since then we question whether the CPS surveys are adequately reflecting what has happened with the number of uninsured children in South Dakota. See Section 1.2.A and Section 1.2.B: Enrollment Charts.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

NA (no change in baseline number estimate).

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
Achieve a measurable reduction in the number of uninsured children in South Dakota.	1. M-SCHIP: Implement Medicaid expansion to cover uninsured children age 6 through 18 to 133% FPL through a CHIP state Plan on 07-01-1998, enrolling 7,352 children by 06-30-1999 and increasing enrollment by 5% each year after the initial year. S-SCHIP: Implement S-SCHIP to provide coverage to an additional 2,400 targeted, uninsured children in families with incomes from 140% to 200% of the federal poverty level beginning 07-01-2000.	1. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS & MR 63: June 1998-September 2001. Methodology: Reduce 1998 CPS base line by actual enrollments in M-SCHIP. Further reduce uninsured children by actual enrollments in S-SCHIP. Progress Summary: FFY 1998 M-SCHIP enrollment 903 FFY 1999 M-SCHIP enrollment 1,585 FFY 2000 M-SCHIP enrollment 1,891 FFY 2001 M-SCHIP enrollment 1,456 Total M-SCHIP enrollment from 7-1-98 through 9-30-01 5,835

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		FFY 2000 S-SCHIP enrollment 301 FFY 2001 S-SCHIP enrollment 1,034 Total S-SCHIP enrollment from 7-1-00 through 9-30-01 1,335
	2. Extend Medicaid to uninsured children age zero through eighteen at Medicaid eligibility levels in effect prior to 07-01-98, enrolling 900 additional children by 06-30-99 and increasing enrollment by 1% each year after the initial year.	2. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS & MR 63: June 1998 - September 2001. Methodology: Reduce 1998 CPS baseline by actual enrollments in Medicaid. Progress Summary: FFY 1998 Medicaid enrollment increase 1,188 FFY 1999 Medicaid enrollment increase 2,381 FFY 2000 Medicaid enrollment increase 2,265 FFY 2001 Medicaid enrollment increase 3,959 Total Medicaid enrollment from 7-1-98 through 9-30-01 9,793
	3. M-SCHIP: Utilize a systematic approach to identify uninsured children with low incomes using Department data resources, partnerships with other public programs, and local involvement of interested parties including schools, providers, and others by July 1, 1998 and continuing each year. S-SCHIP: Will utilize the same systematic approach as M-SCHIP as they are both administered by the same entity, Department of Social Services.	3. NC in M-SCHIP or S-SCHIP, however the Community Healthcare Association of Sioux Falls, South Dakota was a successful applicant for the South Dakota Covering Kids Initiative through grant funding from the Robert Wood Johnson foundation for a three-year period of time from July 1, 2000 through June 30, 2003. The South Dakota Covering Kids Initiative has four goals. They are: designing and conducting outreach programs to identify and enroll children in the Medicaid and SCHIP programs; continuing to simplify access to and completion of enrollment information and applications; assisting in coordinating coverage programs for low income, uninsured children; and designing programming specifically targeted to Native Americans and other special populations. The program will feature statewide initiatives to meet these goals and also pilot programs to address specific geographic areas and special populations.
	4. Simplify the Medicaid application process for low-income children using a shortened application and accepting mail-in applications by July 1, 1998. S-SCHIP: Expand the simplified medical assistance application process to include S-SCHIP the same as the Medicaid and M-SCHIP medical assistance programs.	4. NC in M-SCHIP or S-SCHIP, however applications can also be faxed into the local DSS offices. The application is also on the Web site and may be completed, printed off, and mailed, faxed, or hand delivered to the local DSS offices. Web site address is: www.state.sd.us/social/medical/chip and www.state.sd.us/social/MedElig/.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	5. Increase the number of Department of Social Services personnel to support the enrollment of uninsured children by 12 full time equivalent workers by June 30, 1999.	5. NC in M-SCHIP or S-SCHIP.
Objectives Related to SCHIP Enrollment		
M-SCHIP and S-SCHIP: Achieve a measurable reduction in the number of uninsured children in South Dakota.	M-SCHIP: Implement Medicaid expansion to cover uninsured children age 6 through 18 to 133% FPL through a CHIP State Plan on 07-01-1998, enrolling 7,352 children by 06-30-1999 and increasing enrollment by 5% each year after the initial year. S-SCHIP: Implement S-SCHIP as an additional effort to address the objectives stated in the original state plan effective July 1, 2000. S-SCHIP to provide coverage to an additional 2,400 targeted, uninsured children in families with incomes from 140% to 200% of the federal poverty level beginning July 1, 2000.	Narrative: An M-SCHIP plan was developed and submitted to CMS (HCFA) on 06-05-1998 with approval being received on 08-25-1998. The plan was implemented on July 1, 1998. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS & MR 63: June 1998-September 2001. Methodology: Reduce 1998 CPS baseline by actual enrollments in M-SCHIP and S-SCHIP. Progress Summary: FFY 1998 M-SCHIP enrollment 903 FFY 1999 M-SCHIP enrollment 1,585 FFY 2000 M-SCHIP enrollment 1,891 FFY 2001 M-SCHIP enrollment 1,456 Total M-SCHIP enrollment from 7-1-98 through 9-30-01 5,835 FFY 2000 S-SCHIP enrollment 301 FFY 2001 S-SCHIP enrollment 1,034 Total S-SCHIP enrollment from 7-1-00 through 9-30-01 1,335
Objectives Related to Increasing Medicaid Enrollment		
Achieve a measurable reduction in the number of uninsured children in South Dakota.	Extend Medicaid to uninsured children age zero through eighteen at Medicaid eligibility levels in effect prior to 07-01-98, enrolling 900 additional children by 06-30-99 and increasing enrollment by 1% each year after the initial year.	Data Sources: US census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS & MR 63: June 1998 - September 2000. Methodology: Reduce 1998 CPS baseline by actual enrollments in Medicaid. Progress Summary: FFY 1998 Medicaid enrollment increase 1,188 FFY 1999 Medicaid enrollment increase 2,381 FFY 2000 Medicaid enrollment increase 2,265 FFY 2001 Medicaid enrollment increase 3,959 Total Medicaid enrollment from 7-1-98 through 9-30-01 9,793

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
Improve access to quality primary and preventative health care services under Medicaid for SCHIP eligibles, new Medicaid eligibles, and previously non-enrolled children on July 1, 1998.	M-SCHIP: Enroll all newly approved M-SCHIP children in the South Dakota Medicaid primary care case management program within 1 month of their enrollment, beginning 07-01-1998 (implementation of M-SCHIP). S-SCHIP: Enroll 95% of all newly approved S-SCHIP children in the South Dakota medical assistance primary care case management program within 1 month of their enrollment, beginning July 1, 2000 (implementation of S-SCHIP).	Data Sources: NC for M-SCHIP. Methodology: NC for M-SCHIP. Progress Summary: For FFY 2001 the M-SCHIP managed care participation rate is 99 %. The March 2000 report showed a 98.6% average participation rate. The FFY 2000 annual report showed a 99.5% average participation for managed care for M-SCHIP. For FFY 2001 the S-SCHIP managed care participation rate is 98.5 %. The FFY 2000 annual report showed a 99.9% average managed care participation rate, however this was only for a 3 month time period due to implementation July 1, 2000. Attachment 11: Primary Care Participation enrollment averages FFY 2001
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
Improve access to quality primary and preventative health care services under Medicaid for SCHIP eligibles, new Medicaid eligibles, and previously non-enrolled children.	1. Ensure each new SCHIP enrollee and new Medicaid eligibles receive EPSDT information at the time their eligibility is approved. 2. Develop a quality measurement mechanism that includes measures of immunization, well childcare, adolescent well care, satisfaction and other measures of health care quality.	Data Sources: NC in M-SCHIP or S-SCHIP. Methodology: NC Progress Summary: The Healthy Kids Klub parent reminder letter continues to be sent out from the Department of Social Services to Medicaid and SCHIP households. The Healthy Kids Klub letter is sent out by a monthly automated mailing that is driven by the child's birth date and the preventive services that are recommended for the child's age. The Healthy Kids Klub brochure is given to parents/care takers of children when the child becomes eligible for medical services. Attachment 7: Healthy Kids Klub letter and brochure; HKK Parent letters sent out Tally sheet. 2. Data source: NC in M-SCHIP or S-SCHIP. Methodology: NC in M-SCHIP or S-SCHIP. Progress Summary: Measures completed for each of the identified performance measures in the state plan. Attachment 5: Studies: Immunization ; Well Child Visit ; Optometric ; Mental Health Study/Eating Disorder; Asthma ; Substance Abuse; Dental; Satisfaction of Health Care/Department Survey 2001; Department SCHIP Survey Comparison Chart; Monthly Comparison Chart; Disenrollee

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Survey and Comparison chart.
Other Objectives		
Develop better measurement capabilities of health insurance coverage, health care service availability and quality to children in South Dakota.	1. Develop survey capabilities with the Department of Health to measure the insurance coverage of children in South Dakota by 07-01-98. 2. Modify the MMIS to make M-SCHIP tracking and reporting capabilities available to measure enrollment, service, utilization, and overall program effectiveness. 3. Develop capability to measure access to coverage for Indian children in South Dakota by working jointly with the Indian Health Service, Tribal governments and Urban Indian Health clinics by 07-01-00.	1. Data Sources: NC in M-SCHIP or S-SCHIP. Methodology: NC Progress Summary: Behavioral Risk Factor Surveillance System Survey (BRFSS) information from the Department of Health. Attachment 13: BRFSS Survey 2, Data Sources: NC for M-SCHIP or S-SCHIP. Methodology: NC Progress Summary: NC 3, Data Sources: NC in M-SCHIP or S-SCHIP. Methodology: NC Progress Summary: NC. The Department will continue to maintain a data base on the number and location of providers including IHS and UIH facilities that serve as PCP's to our managed care recipients. Ongoing efforts to develop an information exchange system with IHS facilities to utilize their immunization data for our statewide immunization project. All 20 IHS facilities in South Dakota and 1 IHS facility in North Dakota along with three UIH facilities in the state are participating as PCP's. The American Indian M-SCHIP and S-SCHIP recipients are given the opportunity to select the PCP of their choice. They can receive services at IHS facilities even if they have not selected those providers as their PCP. Attachment 11: Indian Health Service Primary Care Provider (PCP) List Narrative: There are 40 % or 527 out of 1,326 American Indian M-SCHIP recipients using IHS and UIH facilities as of 09-28-01. There are 39 % or 101 out of 261 American Indian S-SCHIP recipients using IHS and UIH facilities as of 09-28-01

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

NA

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

NC

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

M-SCHIP and S-SCHIP enrollees are included in the Medicaid waiver and in the subsequent operation of that waiver.
Attachment 3: Managed Care Waiver 1915(b)

Department surveys with questions relating to access of care and satisfaction of care will continue to be sent to households of SCHIP recipients. The Department survey had previously been done on a yearly basis. In June, 2001 the survey was implemented on a monthly schedule and is sent to 100 randomly selected SCHIP households. Survey results will continue to be reported in the annual reporting requirements. A Disenrollee Survey was developed and implemented September, 2000. This is sent out monthly to a random sample of SCHIP recipients that are no longer enrolled in the program. Results from the data collected during this reporting period are included, however, due to the relative short time that this survey has been implemented, comparisons will be reported on with future reporting requirements.

Attachment 6: Department SCHIP Monthly -Survey; Department SCHIP Survey Comparison Chart - 1998-1999-2000; Department SCHIP Monthly Survey Comparison Chart
Attachment 10: Disenrollee Survey Parent/Caretaker letter; Disenrollee Survey; Disenrollee Survey Comparison Chart

Quality assurance studies will continue to be done in a number of areas. Examples of the studies for SCHIP recipients that have been completed include: Immunization, Well Child Visits, Optometric Services, Mental Health/Eating Disorders, Asthma, Substance Abuse, and Dental Services. We will continue these Quality Assurance studies and will pursue action to obtain measurable improvement. Future study results will be included with reporting requirements.

Attachment 5: Studies: Immunization; Well Child Visit; Optometric; Mental Health/Eating Disorder; Asthma; Substance Abuse; Dental.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Attachment 1: 301-M Application; 301-R Review form; 205-M form
Attachment 2: Bookmark; Coloring Book; Regular size brochure & Mini brochure; Outreach Training Guide
Attachment 3: South Dakota Managed Care Waiver 1915(b)
Attachment 4: Medical Assistant Recipient Handbook (revised 08-01)
Attachment 5: Studies: Immunization; Well Child Visit; Optometric; Mental Health/Eating Disorder; Asthma; Substance Abuse; Dental;
Attachment 6: Department SCHIP Monthly Survey; Department SCHIP Survey Comparison Chart - 1998-1999-2000; Department SCHIP Monthly Comparison Chart
Attachment 7: Healthy Kids Klub brochure; Parent Reminder Letters; Healthy Kids Klub Postcard; Monthly Tally Sheet of Healthy Kid Klub letters sent;
Attachment 8: FFY 2001 HCFA-64.EC, HCFA-64.21 E, HCFA-21E.
Attachment 9: FFY 2001 HCFA-64.21U
Attachment 10: Disenrollee Survey; Disenrollee Survey Comparison Chart; Disenrollee Survey Parent/Caretaker letter
Attachment 11: Primary Care Participation enrollment averages FFY 2001; Indian Health Service Primary Care Provider (PCP) list; List - Number & Type of PCP's
Attachment 12: Crowd Out Analysis; Average Length of Stay Analysis
Attachment 13: Behavioral Risk Factor Surveillance System Survey
Attachment 14: County Enrollment Chart of SCHIP enrollees
Attachment 15: Various Outreach Information for SCHIP and the Healthy Kids Klub: SCHIP Outreach Statewide and Local; CHIP Outreach Field Program Specialist Sheet; DSS Provider Newsletters; SCHIP Packet Cover letters (Elementary School Principal; Shelters; school nurse; school counselor; Head Start Health Coordinator; Early Head Start Health Coordinator; Head Start Director; Early Head Start Director; Housing Authority; libraries); Medicaid providers; DSS Eligibility Determination Staff; Department of Health service areas; Child Care Office Monthly Tally SCHIP for Packets.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

NA

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults
_____Number of children

NA

C. How do you monitor cost-effectiveness of family coverage?

NA

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

NA

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

NA

_____Number of adults
_____Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

NC for M-SCHIP.

NC for S-SCHIP.

Crowd out is defined as the act of replacing existing private or group health insurance with State-Federal funded medical assistance.

B. How do you monitor and measure whether crowd-out is occurring?

The Department requires that insurance information on the persons seeking medical assistance coverage be provided on the application for SCHIP as a measure to avoid substitution for group health coverage. The Department also requires that members of the SCHIP unit cooperates with the Department to determine the availability of coverage. Failure to cooperate may result in loss of eligibility.

The Department also maintains a database on persons with insurance coverage for persons applying for or receiving medical assistance from the Department under Medicaid, M-SCHIP or S-SCHIP. The database includes type of coverage, name and address of carrier, policy numbers, plan sponsor, premium payer, and dates of coverage. Information from this database is available to caseworkers to explore potential group health coverage. Caseworkers also have the opportunity to update the information on this database to keep the information up to date.

South Dakota will continue to study the effects of its enrollment policies on the possible substitution of SCHIP coverage for private group coverage.

The Department of Social Services developed and administered a random survey containing questions relating to insurance coverage to address crowd out. The results of the 1998 survey showed that only a small number, 3 out of 82, dropped their private health insurance because M-SCHIP was available. The December 1999 Department SCHIP survey results showed that out of 305 responses, 3 indicated they had dropped insurance because of the availability of M-SCHIP for a rate of 1%. In the November 2000 Department SCHIP survey, sent to both M-SCHIP and S-SCHIP households, out of 266 responses 1 responded that they had dropped their insurance for the SCHIP program, for a rate of 0.3%. When we compare the results from the 1998, 1999, and 2000 surveys, we find that the numbers of respondents that have dropped their insurance coverage due to the SCHIP programs is low and actually decreased in the second year, and decreased again in the third year of operation. The Department SCHIP monthly surveys were changed from a yearly mailing to monthly mailings beginning June, 2001. Out of 176 survey responses only 4 have indicated that they dropped insurance because SCHIP was available for a rate of 2%. We are aware that this is an important issue and plan to continue monitoring in this area.

Attachment 6: Department SCHIP Comparison Chart - 1998- 1999- 2000; Department Monthly SCHIP Comparison Chart.; Department Monthly SCHIP survey; Department SCHIP survey.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

NC for M-SCHIP.

S-SCHIP:
During this reporting period, October 2000 through September 2001, 9 applicants were identified as having dropped group health insurance within 3 months prior to application. In accordance with South Dakota S-SCHIP policy, 46 applicants were found ineligible for S-SCHIP coverage due to already having insurance coverage.

This data is gathered and made available through the eligibility determination computer system.

Attachment 12: Crowd Out Analysis

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Our program design provides no incentive for a family to drop insurance coverage because the children who are insured qualify for benefits under Medicaid and only the children who are uninsured are enrolled in SCHIP. In as much as families already made their decision to have insurance, additional benefits of having Medicaid insurance are still available to them.

S-SCHIP was implemented July 1, 2000. There are in place specific measures to prevent the program from substituting for coverage under group health plans. The first measure is simply that persons covered by insurance providing hospital and medical services or HMO's are not eligible for benefits under the S-SCHIP program. Another measure to prevent substitution is that children are ineligible if they have been covered by a group health plan in the 3 months immediately preceding the application for S-SCHIP. The Department has adopted a definition of group health plan that includes employers, self-employed plans, employee organizations, and self insured plans that provide health care directly or otherwise. There are exceptions to the 3-month rule if there is good cause for dropping insurance under a group health plan if the insurance is dropped for reasons beyond the caretaker's control. Reasons for dropping the insurance includes circumstances such as the following: (1) the cost of the insurance to cover the parent's children exceeds five percent of the S-SCHIP unit's gross income; (2) the parent providing the primary insurance is fired; (3) the parent providing the primary insurance voluntarily quits a job and has not started a new job; (4) the parent providing the primary insurance is laid off; (5) the parent providing the primary insurance becomes disabled; (7) the parent providing the

primary insurance starts a new job and there is a lapse in insurance or the new employer does not provide dependent coverage; or (8) the employer discontinued the insurance. South Dakota will continue to study the effects of its enrollment policies on the possible substitution of S-SCHIP coverage for private group coverage.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

- Having applications and information available to medical providers and community agencies.
- Cooperation with other State agencies for SCHIP outreach. See Section 3.1.H. See Attachment 15: Various Outreach Information for SCHIP and the Healthy Kids Klub.
- Cooperation from schools by nurses, counselors, and administrators as well as Head Start programs as they work to get SCHIP information out to families with children, and also work with individual families and children regarding SCHIP.
- Involvement in local community projects such as Health fairs, etc.
- Television media and news stories involving SCHIP.
- Staying in contact with places that the Department of Social Services has previously provided outreach and making sure they have updated material and a supply of applications and brochures.

The SCHIP Department survey has questions relating to where applicants heard about the program and where they obtained the application. The Monthly Department surveys that began June, 2001 show 46 % heard about the SCHIP program from the Department of Social Services. The survey done in November, 2000 showed that 47% heard about the SCHIP program from the Department of Social Services compared to 55% in the 1999 survey and 76.1 in the 1998 survey. This decrease in percentage shows that families are learning and continue to learn about the SCHIP program from a variety of sources as opposed to the majority learning about it through Social Services as was evident at the implementation of SCHIP in 1998.

Attachment 6: Department SCHIP Survey Comparison - 1998-1999-2000;
Department SCHIP Survey - Monthly Comparison

The SCHIP Department Survey 2001 results also revealed that 83 % of the applications for SCHIP were obtained from the Department of Social Services as compared to 93% in 1998 with the implementation of SCHIP. The decrease in percentages in this area shows that applications are being obtained from sources other than the Department of Social Services.

A specific increase in phone call inquiries requesting SCHIP information and applications has been noted following television news stories and campaigns

regarding SCHIP. There have been a total of 1,685 calls recorded during this reporting period to the South Dakota 1-800 number for SCHIP information. This is in addition to the calls that come in directly to the Department of Social Services offices.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

In general we have found that on the Reservations, the most successful outreach has been coordination with IHS and Tribal governments.

To measure effectiveness, some areas have marked applications given out by school nurses, Head Start programs, hospitals, health fairs, etc. However, some families that learn about the SCHIP program from these locations did not always take the marked applications, but instead got an unmarked application from another source.

C. Which methods best reached which populations? How have you measured effectiveness?

IHS and Tribal medical providers help reach American Indian populations. Contacts with health providers at the various vocational schools, colleges, and universities have been useful in reaching non-traditional students and those under 19 who are on their own. Contacts with the various Birth-to-Three agencies (previously called Interagency Coordinating Councils) have also resulted in referrals of eligible children.

Brochures and application packets have worked the best with these contacts as they can keep them and provide them to families that they are in contact with. The application on the Web site is an excellent method for reaching families as more families gain access to the Internet. This also allows agencies and providers to have immediate access to an application if they have never had them or if their supply has not been replenished.

The only way that we can measure effectiveness with these families is with anecdotal information on how they learned about the program. Local offices keep track of Internet applications as they are aware of them. The Monthly Department SCHIP survey has questions regarding how they heard about the SCHIP program and where they got the application.

Attachment 6: Department Monthly SCHIP survey; Department Monthly SCHIP comparison chart

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

M-SCHIP and S-SCHIP Review Process:

All possible medical program eligibility is explored before a recipient is closed from medical assistance. Eligibility remains until a determination of ineligibility is made. Once eligible for a medical assistance provision, the child can move from one medical assistance provision to another without another application so long as there is not a break (at least 30 days) in eligibility.

Medical reviews must be completed annually. However, any of the following may be used as review documentation:

- Information already available in the case record (Food Stamp or TANF monthly report form, Transitional Medical Benefit quarterly report form, or information reported and verified by the client verbally, or in writing along with applicable verifications)
- Completion of a 301R Medical Review form
- Completion of a new 301M Medical application form
- Completion of a new 301 (Food Stamp or TANF application)

No signed application or interview is required for a medical review. Caseworkers may complete the review form via a telephone contact to the head of household. Any requested documentation may be submitted via mail or fax. If at the established review time there is sufficient information available to redetermine eligibility, then the medical review is considered complete.

If no existing information is available to complete the review, then at least two client contacts will be made in an attempt to gather needed review information.

Attachment 1: 301-R; 205-M

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__X__ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families

__X__ Targeted mailing to selected populations, specify population _Households with Disenrolled children.

__X__ Information campaigns
__X__ Simplification of re-enrollment process, please describe See Section: 1.1.F.
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe Disenrollee Surveys sent out monthly, implemented 09-2000.
____ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

The same measures listed in 2.5.B are being used in Medicaid with the exception of Disenrollee surveys. The Disenrollee surveys were implemented September, 2000 and are currently only being sent to SCHIP disenrollee households.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Eligibility staff screens all recipients for potential eligibility in any medical assistance program to ensure all possible medical eligibility is explored.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

The Disenrollee survey was implemented September, 2000. This is a random survey that is being sent out monthly to households were children have become disenrolled. Due to the fact that this survey has only been implemented for a one year time period there is not sufficient data to do an analysis for comparison purposes. However, the survey for one year has revealed the following information: 17% of the participants that are no longer enrolled in the program now have other health insurance and another 9% stated they have access to free health insurance through another source; 43 % replied they were over the income limit; and 19 % stated the child was 19 years or older. For other responses see Attachment 10.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

NC in M-SCHIP.
NC in S-SCHIP.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

NC in M-SCHIP.
NC in S-SCHIP.

SCHIP forms and procedures are identical to those utilized for Medicaid. This also includes utilization of the same staff to make eligibility determinations and a single computer eligibility determination system. Once a child is determined eligible for Medicaid, M-SCHIP or S-SCHIP the eligibility remains until a determination has been made that the child is no longer eligible for Medicaid, M-SCHIP or S-SCHIP. This seamless process allows children to transfer from one medical program to another without interruption when eligibility criteria changes, but the child remains eligible for Medicaid, M-SCHIP or S-SCHIP.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

NC in M-SCHIP.
NC in S-SCHIP.

Health care services for SCHIP programs are delivered using the existing Medicaid delivery and payment systems including primary care case management and access to specialty health service providers, as approved under the State's 1915(b) waiver under Medicaid. The State can assure that children receiving services under the SCHIP programs will receive the same beneficiary protections as children receiving Medicaid coverage including grievances and appeals, privacy and confidentiality, respect and non-discrimination, access to emergency services, and an opportunity to participate in health care treatment decision and choice of providers. Benefits delivered to targeted uninsured children under the SCHIP state administered programs are identical to the benefits offered under the State's Medicaid program, including EPSDT benefits. The State can also assure that it is providing SCHIP services in an effective and efficient manner by using Medicaid policies and procedures.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

NA

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

NA

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

SCHIP recipients are enrolled in the Primary Care Case Management(PCCM) program and become part of the managed care population. Since they are a part of the managed care program they benefit from the PCCM standards for access to and quality of care services. Most of the specialized physicians participate, all hospitals in the state participate, all IHS participates, pharmacies almost have universal participation and dental participation is 79%. The statewide PCP/enrollee ratio as of September, 2001 is one provider to every 99 managed care recipients. See table below for the numbers of providers by specialty that are currently serving our managed care population that also includes SCHIP enrollees.

Count of the number and type of PCP's

(Data from DSS Managed Care as of September, 2001)

Prov type	In-State	Out-of-State	Grand Total
AFB Clinic	1		1
Family Practice	247	74	321
FQHC	24	1	25
IHS	21	1	22
Internal Med	98	3	101
OB/GYN	60	1	61
Pediatrics	50	8	58
RHC	52	8	60
Grand Total	553	96	649

Time and distance standards are that no recipient in the state has to travel more then 75 miles to an available Primary Care Provider (PCP). If they have to travel more then this distance, they may be exempt from managed care. Also, they are included in the managed care studies.

The Department of Social Services developed and administered a random survey that has been sent out yearly since the implementation of SCHIP. This survey is sent to current recipient households. Beginning June, 2001 the random survey was changed to a monthly mailing to SCHIP recipient households. Specific questions are targeted to access of care and satisfaction.

Attachment 6: Monthly Department Survey; Monthly Department Comparison chart

The following results were noted from the monthly surveys that have been conducted over the time frame from June, 2001 through September, 2001 during this reporting period.

- 97 % responded they felt that the PCP was providing quality care for their child. This is comparable to the responses from last years survey results.
- 65 % responded that their child had at least one visit for a routine well child care check up with their primary care provider, not related to illness or injury since enrollment in SCHIP. Last years survey netted a 66 % response rate to the question.

- 61 % reported their child had a dental examination since enrolling in the SCHIP programs. The second part of the question showed that 37 % of the children needed dental care but did not receive it due to cost before being covered by SCHIP. There has been a 4 % increase from last years survey results of 57 % having had a dental examination since enrolled in SCHIP.

- 46 % reported having a vision exam since being enrolled in SCHIP. Part two of the question showed 14 % needed vision care but did not receive it due to cost before being covered by SCHIP.

In comparing the Department SCHIP surveys, the respondents consistently report that they are satisfied with the quality of care their child is receiving on the program. It should be noted that although children are receiving well childcare visits, this is one area where continual promotion of preventative services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is necessary. EPSDT parent or caretaker reminder letters are sent out from the Department of Social Services monthly. These letters are generated matching the child's birth date with the recommended preventative services, immunizations and well child care visits that are due for the child's specific age.

A Healthy Kids Klub (promotional name for EPSDT services in South Dakota) postcard was developed as a reminder to use the free preventative services that available to children as part of their routine health care needs. This was sent out to approximately 3,700 SCHIP households August, 2001 to encourage families to get well childcare checkups for their children prior to the beginning of the new school year. The Healthy Kids Klub brochure is included with the SCHIP promotional outreach material that is sent to schools, Head Starts, providers, and other community agencies and groups that are participating in outreach efforts for SCHIP.

A Disenrollee Survey was implemented September, 2000. This survey is sent out monthly to random SCHIP recipient households. Questions regarding quality of care and satisfaction were included on the survey with the following results being noted:

- 86% responded they were satisfied with the quality of care they received from their Primary Care Provider while enrolled in CHIP. It should be noted that 10 % responded that the child was not seen during the time they were enrolled.

- 55 % responded they were satisfied with being able to see a specialist for their child when needed, and another 42 % responded their child did not need any appointments

with a specialist while enrolled in the program.

Attachment 7: Healthy Kids Klub reminder letter; Healthy Kids Klub brochure.
Attachment 6: SCHIP Department Monthly Survey; Monthly Department SCHIP Comparison Chart;
Attachment 10: Disenrollee Survey; Disenrollee Survey Comparison Chart

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

SCHIP enrollees are included in the Medicaid managed care waiver and are included in the operation of the waiver.

Department surveys with questions relating to access of care continue to be sent to households of SCHIP recipients. These surveys are now done on a monthly basis with an ongoing comparison of responses. A Disenrollee Survey was also implemented with quality of care questions included in the survey. The responses will be monitored on an ongoing basis. Studies regarding utilization of services for well-child care visits, immunizations, mental health, substance abuse, dental, and vision will continue to be done on a periodic basis and the results will be included in the reporting requirements for SCHIP. See 1.7: Attachments.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

SCHIP enrollees are included in the Medicaid waiver 1915(b) and are enrolled in the Primary Care Case Management (PCCM) system. Since they are a part of the managed care program they benefit from the same methods that exist for the Medicaid enrollees to assure quality and appropriateness of care.

The most comprehensive mechanism to be used by the State in the SCHIP program is the Primary Care Case Management(PCCM) system.

Department surveys and Disenrollee surveys with questions relating to access of care will continue to be sent to households of SCHIP recipients. We will continue to survey on a periodic basis.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

Application revised for ease of understanding for lower level readers.

Attachment 1: 301-M

B. Outreach

Department of Social Services case workers continue to expand outreach efforts in their local communities reaching a diversified group including families, agencies, organizations, schools, and health care providers.

Revisions were made to the SCHIP brochure September, 2001, and a SCHIP coloring book and bookmark were also developed to be used in outreach promotions for the program. A mini version of the SCHIP brochure was developed November, 2001 to be used with unemployment checks in an outreach effort with the Department of Labor to reach potentially eligible children in families that have become unemployed. Current plans are to mail these mini brochures with the December, 2001 and January, 2002 unemployment checks, with another mailing targeted for Spring, 2002.

The Community Healthcare Association of Sioux Falls, South Dakota was a successful applicant for the South Dakota Covering Kids Initiative through grant funding from the Robert Wood Johnson foundation for a three-year period of time from July 1, 2000 through June 30, 2003. The program continues to work on the established goals and also pilot programs to address specific geographic areas and special populations.

Attachment 2: CHIP brochure; color book; bookmark.

C. Enrollment

In FFY 2001 we added a total of 6,449 uninsured children to Medicaid, M-SCHIP, and S-SCHIP. Enrollment breakouts per category:

Medicaid = 3,959
M-SCHIP=1,456
S-SCHIP =1,034

Data taken from South Dakota Medicaid and SCHIP programs enrollment data. See Table in 1.2.A.

D. Retention/disenrollment

M-SCHIP and S-SCHIP Review Process:

All possible medical program eligibility is explored before a recipient is closed from medical assistance. Eligibility remains until a determination of ineligibility is made. Once eligible for a medical assistance provision, the child can move from one medical assistance provision to another without another application so long as there is not a break (at least 30 days) in eligibility.

Medical reviews must be completed annually. However, any of the following may be used as review documentation:

- Information already available in the case record (Food Stamp or TANF monthly report form, Transitional Medical Benefit quarterly report form, or information reported and verified by the client verbally, or in writing along with applicable verifications)
- Completion of a 301-R Medical Review form
- Completion of a new 301-M Medical application form
- Completion of a new 301 (Food Stamp or TANF application)

No signed application or interview is required for a medical review. Caseworkers may complete the review form via a telephone contact to the head of household. Any requested documentation may be submitted via mail or fax. If at the established review time there is sufficient information available to redetermine eligibility, then the medical review is considered complete.

If no existing information is available to complete the review, then at least two client contacts will be made in an attempt to gather needed review information.

Attachment 1: 301-R; 205-M

Disenrollee Surveys were began September, 2000 to SCHIP participants that are no longer enrolled in the medical assistance program. This survey will be continued, however, due to the limited time this survey has been in use the findings are not

conclusive for purposes of a year to year comparison . See Attachment for responses for one year of survey results.

Attachment 10: Disenrollee Survey Results and Disenrollee Survey

E. Benefit structure

NC

F. Cost-sharing

NC

G. Delivery system

NC

H. Coordination with other programs

The Department of Health, as a collaborative effort with the Department of Social Services, coordinates outreach and referrals to SCHIP through programs that include: WIC, immunizations, Family Planning, Baby Care case management, postpartum services, Community Health Services, All Women Count, and Children's Special Health Services. They have also marketed SCHIP through their health fairs, in conjunction with their information to local radio stations, and presentations to various community groups and events.

The Department of Social Services had representatives for the SCHIP program at the resource roundtable at the Coordinated School Health Leadership Institute in June, 2001.

The Department of Education is an active partner in outreach efforts. Mailings through our office have targeted school administration, school nurses and counselors on a statewide basis as well as the local contacts that continue on an ongoing scheduled basis through the local Department of Social Service offices. Head Start and Early Head Start programs have also been included SCHIP information with their school outreach mailings.

Collaboration with the Department of Labor continues as an ongoing endeavor.
A mini version of the SCHIP brochure was developed November, 2001 to be used in the mailings with unemployment checks for December, 2001 and January, 2002 plus one other mailing planned for Spring, 2002. This outreach effort with the Department of Labor is to reach potentially eligible children in families that have become unemployed.

The Office of Child Care is an ongoing active partner in SCHIP outreach. Licensing distribution through the Child Care licensing staff at sites throughout the State have included distribution of 991 SCHIP Inquiry packets. These packets of SCHIP information was distributed to individuals interested in setting up some type of child care program from January, 2001 through September, 2001. There were also 33 group meetings of individuals or specifically with a provider from June, 2001 through November, 2001 in addition to the 991 packets dispersed. The programs through this office that have included the above SCHIP Inquiry packets include: Before & After School programs and centers, Day Care Centers, and Group Family Day Care Homes, and Family Day Care Homes.

Coordination with Food Stamp and TANF programs is a continuous collaborative effort with the Department of Social Services.

The Department of Social Services representatives continue to collaborate with the Covering Kids Coalition and attend Coalition quarterly meetings.

I. Crowd-out

NC

J. Other

NC

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs	-0-	-0-	-0-
Insurance payments	-0-	-0-	-0-
Managed care			
per member/per month rate X # of eligibles			
Fee for Service	5,721,078	6,855,450	8,339,785
Total Benefit Costs	5,721,078	6,855,450	8,339,785
(Offsetting beneficiary cost sharing payments)	-0-	-0-	-0-
Net Benefit Costs	$5,721,078	$6,855,450	$8,339,785
Administration Costs			
Personnel			
General administration	$282,527	$338,552	$536,082
Contractors/Brokers (e.g., enrollment contractors)	-0-	-0-	-0-
Claims Processing			
Outreach/marketing costs	156,971	188,098	297,897
Other			
Total Administration Costs	439,498	526,650	833,979
10% Administrative Cost Ceiling	635,675	761,717	833,979
Federal Share (multiplied by enhanced FMAP rate)	4,794,160	5,621,469	6,985,821
State Share	1,366,416	1,760,631	2,187,943
TOTAL PROGRAM COSTS	$6,160,576	$7,382,100	$9,173,764

Attachment 9: FFY 2001 HCFA- 64.21U

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

NA

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

X State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	M-SCHIP (CHIP)	S-SCHIP (CHIP-NM)
Provides presumptive eligibility for children	_X_ No _____ Yes, for whom and how long?	_X_ No _____ Yes, for whom and how long?
Provides retroactive eligibility	_____ No _X_ Yes, for whom and how long? 3 months prior to the month the application is received by the Department of Social Services office.	_____ No _X_ Yes, for whom and how long? 3 months prior to the month the application is received by the Department of Social Services office.
Makes eligibility determination	_X_ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)*	_X_ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)*
Average length of stay on program	Specify months 11.9 months See Attachment 12: Analysis of Average Length of Stay.	Specify months 15.8 months See Attachment 12: Analysis of Average Length of Stay.
Has joint application for Medicaid and SCHIP	_____ No _X_ Yes	_____ No _X_ Yes
Has a mail-in application	_____ No _X_ Yes	_____ No _X_ Yes
Can apply for program over phone	_X_ No _____ Yes	_X_ No _____ Yes
Can apply for program over internet	_X_ No, however, the application can be printed from the Internet Web site, completed and then returned by fax, mail, or hand delivered to the local Department of Social Service office. _____ Yes	_X_ No, however, the application can be printed from the Internet Web site, completed and then returned by fax, mail, or hand delivered to the local Department of Social Service office. _____ Yes
Requires face-to-face interview during initial application	_X_ No _____ Yes	_X_ No _____ Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_X_ No _____ Yes, specify number of months What exemptions do you provide?	_____ No _X_ Yes, specify number of months _3 months What exemptions do you provide? Requires child to be without group health insurance within 3 month period prior to approval unless good

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
		cause exists. Good cause for dropping insurance under a group health plan exists if the insurance is dropped for reasons beyond the caretaker's control. Reasons for dropping the insurance includes circumstances such as the following: (1) the cost of the insurance to cover the parent's children exceeds five percent of the S-SCHIP unit's gross income; (2) the parent providing the primary insurance is fired; (3) the parent providing the primary insurance voluntarily quits a job and has not started a new job; (4) the parent providing the primary insurance is laid off; (5) the parent providing the primary insurance becomes disabled; (6) the parent providing the primary insurance dies; (7) the parent providing the primary insurance starts a new job and there is a lapse in insurance or the new employer does not provide dependent coverage; or (8) the employer discontinued the insurance.
Provides period of continuous coverage regardless of income changes	__X__No _____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	__X__No _____Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	__X__No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	__X__No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	__X__No _____Yes	__X__No _____Yes
Provides preprinted redetermination process	__X__ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__X__ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

M-SCHIP and S-SCHIP Review Process:

All possible medical program eligibility is explored before a recipient is closed from medical assistance. Eligibility remains until a determination of ineligibility is made. Once eligible for a medical assistance provision, the child can move from one medical

assistance provision to another without another application so long as there is not a break (at least 30 days) in eligibility.

Medical reviews must be completed annually. However, any of the following may be used as review documentation:

- Information already available in the case record (Food Stamp or TANF monthly report form, Transitional Medical Benefit quarterly report form, or information reported and verified by the client verbally, or in writing along with applicable verifications)
- Completion of a 301-R Medical Review form
- Completion of a new 301-M Medical application form
- Completion of a new 301 (Food Stamp or TANF application)

No signed application or interview is required for a medical review. Caseworkers may complete the review form via a telephone contact to the head of household. Any requested documentation may be submitted via mail or fax. If at the established review time there is sufficient information available to redetermine eligibility, then the medical review is considered complete.

If no existing information is available to complete the review, then at least two client contacts will be made in an attempt to gather needed review information.

Attachment 1: 301-R; 205-M

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

_140 % of FPL for children under age __19____
____% of FPL for children aged _____
____% of FPL for children aged _____

Medicaid SCHIP Expansion

_140 % of FPL for children aged ___19_____
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

_200% of FPL for children aged ____19_____
____% of FPL for children aged _____
____% of FPL for children aged_____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes _X_ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$ 90.00 or 20% of Gross which ever is larger.	$ 90.00 or 20% of Gross which ever is larger.	$ None
Self-employment expenses	$ Deductions from self-employment: to determine net income from self-employment, subtract the costs of producing the income from the gross income. Costs of producing the income include the cost of merchandise and building or equipment rental, but do not include depreciation, personal shelter expenses, or the purchase of capital assets, such as a building, equipment, machinery, or property. Personal expenses, such as income tax, social security tax, lunches, and transportation to and from work are not considered a cost of producing income.	$ Deductions from self-employment: to determine net income from self-employment, subtract the costs of producing the income from the gross income. Costs of producing the income include the cost of merchandise and building or equipment rental, but do not include depreciation, personal shelter expenses, or the purchase of capital assets, such as a building, equipment, machinery, or property. Personal expenses, such as income tax, social security tax, lunches, and transportation to and from work are not considered a cost of producing income.	$ Deductions from self-employment: to determine net income from self-employment, subtract the costs of producing the income from the gross income. Costs of producing the income include the cost of merchandise and building or equipment rental, but do not include depreciation, personal shelter expenses, or the purchase of capital assets, such as a building, equipment, machinery, or property. Personal expenses, such as income tax, social security tax, lunches, and transportation to and from work are not considered a cost of producing income.
Alimony payments Received	$ 50.00 of the combined alimony payment received and child support payments received is disregard.	$ 50.00 of the combined alimony payment received and child support payments received is disregard.	$ 50.00 of the combined alimony payment received and child support payments received is disregard.
Paid	$ actual court ordered amount paid out	$ actual court ordered amount paid out	$ actual court ordered amount paid out
Child support payments Received	$ 50.00 of the combined alimony payment received and child support payments received is disregard.	$ 50.00 of the combined alimony payment received and child support payments received is disregard.	$ 50.00 of the combined alimony payment received and child support payments received is disregard.
Paid	$ actual court ordered amount paid out	$ actual court ordered amount paid out	$ actual court ordered amount paid out
Child care expenses	$ actual amount due to employment	$ actual amount due to employment	$ actual amount to a maximum of $ 500.00 due to employment.
Medical care expenses	$ -0-	$ -0-	$ -0-
Gifts	$ 30.00 per quarter per household member	$ 30.00 per quarter per household member	$ 30.00 per quarter per household member
Other types of disregards/deductions (specify)	$ earnings of dependent children; earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g. Serve America); earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g. Vista); income from college work-study programs; education assistance programs administered by the Department of Education; education loans and awards; earned income tax credit (EITC); in-kind income if unearned; welfare cash	$ earnings of dependent children; earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g. Serve America); earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., Vista); income from college work-study programs; education assistance programs administered by the Department of Education; education loans and awards; earned income tax	$ earnings of dependent children; earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g. Serve America); earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g. Vista); income from college work-study programs; education assistance programs administered by the Department of Education;

Table 6.2			
	benefits (TANF); Supplemental Security Income cash benefits; housing subsidies; foster care cash benefits; adoption assistance cash benefits; emergency or disaster relief benefits; low income energy assistance payments.	credit (EITC); in-kind (TANF); Supplemental Security Income cash benefits; housing subsidies; foster care cash benefits; adoption assistance cash benefits; emergency or disaster relief benefits; low income energy assistance payments.	education loans and awards; earned income tax credit (EITC); in-kind (TANF); Supplemental Security Income cash benefits; housing subsidies; foster care cash benefits; adoption assistance cash benefits; emergency or disaster relief benefits; low income energy assistance payments.

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

_X_No___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

__X__No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

__X__No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____NA_____

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes _X__ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage

None

B. Employer sponsored insurance buy-in

None

C. 1115 waiver

No

D. Eligibility including presumptive and continuous eligibility

No

E. Outreach

NC

F. Enrollment/redetermination process

Revised the application form 301-M, and created the Review Form 301-R and established a flexible review process for redetermination. See: 1.1.F.

Attachment 1: 301-M ; 301-R; 205-M

G. Contracting

No

H. Other

NA